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ABSTRACT

Developed as part of the Child and Adolescent Health Profile Project, this annotated bibliography is intended as a reference for professionals interested in key dimensions of children's health. Citations are grouped into the following four categories: (1) background information on child health issues, (2) child health indicators and health status measures, (3) mainly national child health profiles, and (4) health indexes. Providing a backdrop for profile development, Section 1 lists publications that can help readers gain an overview of the key child health issues and the role of data in informed policymaking and planning. Section 2 contains references to publications about statistics used to measure the health status of children; among topics addressed are the definition of health status measures and data validity, reliability, and availability. References to compendia of child health measures are included in Section 3. Section 4 contains references to measures which summarize data from two or more components of health status or quality of life and which purport to reflect the health status of an individual or defined group. Publications addressing more than one topic are categorized according to their major emphasis. Most of the materials were published since 1980; the few references predating 1980 have been included because they represent particularly significant contributions to the field. (RH)

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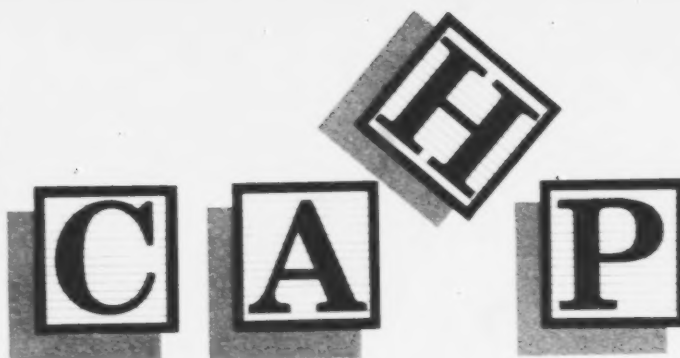
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Child and Adolescent Health

PROFILE

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Annotated Bibliography

CHILD AND ADOLESCENT HEALTH PROFILE PROJECT

The Child and Adolescent Health Profile Project is a three-year federally funded project to design and develop a model statistical health profile containing key health, access, and sociodemographic indicators for children and adolescents. The project represents a major initiative to identify and integrate health-related data concerning New York State's children and adolescents for the purposes of monitoring their health status, obtaining an overview of their preventive and primary care needs, and monitoring the impact of policies and programs.

Collaborating on the project with Welfare Research, Inc., are the New York State Council on Children and Families and the New York State Department of Health.

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The opinions expressed herein are the authors' and do not necessarily reflect the views of the granting agency.

WRI, Albany, NY, 1986

CHILD AND ADOLESCENT HEALTH

PROFILE PROJECT

Annotated Bibliography

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FOREWORD

This annotated bibliography was developed as part of the Child and Adolescent Health Profile (CAHP) Project*. It is intended as a reference for professionals who are interested in compiling and summarizing the key dimensions of children's health.

The publications cited all address the documentation of children's health status for planning, policy development, and/or monitoring and evaluation activities. (In defining our target population--children--we have chosen to be inclusive, spanning the age range from birth through the teen years.)

For reference purposes, we have divided the publications into the following topic categories:

- background information on child health issues (p. 1)
- child health indicators and health status measures (p. 7)
- child health profiles (p. 25)
- health indexes (p. 35)

The user of this bibliography is cautioned, however, that some of these publications address more than one topic. Such publications are categorized according to their major emphasis.

Almost all of the materials described here have been published since 1980. The few references that predate 1980 are included because they represent particularly significant contributions to the field.

*CAHP is a Maternal and Child Health Improvement Project (MCHIP), supported by the Division of Maternal and Child Health, Health Resources and Services Administration, Public Health Service.

The section entitled "Background Information on Child Health Issues" lists publications that can help readers gain an overview of the key child health issues and the role of data for informed policy and planning related to these issues. This section also contains articles that discuss definitions of "health." Together this assortment of references provides a backdrop for profile development. The specific health measures selected for profiles and data presentation formats will be determined in large part by the purpose that the profile is intended to serve, the compiler's definition of health, and the data that are readily available. The literature in this background section takes note of the fact that the "health" of populations has traditionally been measured by mortality rates and that, more recently, researchers have defined health in terms of the presence/absence of specific illness and conditions. Such events have been defined either narrowly, along physical dimensions, or broadly, with the inclusion of social, mental, educational, and other dimensions. Some attention has recently focused on the need to define and measure the positive aspects of health and well-being.

Literature on critical issues in child health is included to help potential profile developers think about indicators that reflect matters of greatest concern to policymakers, health professionals, and advocates. Not only should the target audience be considered during profile development, but the intended purpose of the final product must be considered as well.

The section "Child Health Indicators and Health Status Measures" contains references to publications about statistics that have been used to measure the health status of children. Among the topics addressed by these publications are the definition of health status measures and data validity, reliability, and availability.

Actual samples of compendiums of child health measures are included in the "Child Health Profile" section of the bibliography. Most of the profiles are national in scope, but a few profiles developed in New York, California, and Washington are also included.

References to "Health Indexes" comprise the fourth section of this bibliography. As defined by Donald Patrick,* a health status index is "a measure which summarizes data from two or more components of health status or quality of life and which purports to reflect the health status of an individual or defined group." The field of health indicator development has made considerable progress over the last fifteen years. In light of the research that has gone into the identification of index components, these references are included in this bibliography. The references will assist those health data users who are interested in summarizing a set of discrete measures. Cited here are those articles that are comprehensible to a reader without prior expertise in the field. Bibliographies containing references to the more technical aspects of index development are contained in several of the publications that we have cited.

In this bibliography, annotations written by the original author(s) (as abstracts or summaries in the text) were used when available, with the source noted in brackets at the end of the annotation. Annotations provided by the Clearinghouse on Health Indexes or data bases were also used and their sources are noted in brackets as well. Publications for which no published abstracts were available, were summarized by CAHP project staff, with emphasis given to the content related most specifically to the development of a child and adolescent health profile (such as data sources, limitations, and the child health indicators used).

*Advances in Health Status Assessment Workshop at the American Public Health Association Meeting, 11/17/85.

Our observations regarding the state of the art of child and adolescent health profiles based on this body of literature can be summarized as follows:

- There is consensus that child and adolescent health indicator data are needed for informed policymaking, planning, monitoring, and evaluation.
- Researchers agree that, today, mortality statistics alone are insufficient measures of health status. Other indicators used in recently published statistical health profiles of children are fairly similar, in part because there is agreement about the validity of these measures and possibly in part because the availability of certain data drives the selection of indicators. In addition to mortality statistics, health profiles contain measures of selected illnesses and health conditions, risk factors, functioning and disability, and measures of access to care. Thus, although there is much discussion about the need to find measures of child development as well as some of the more positive aspects of health, profiles routinely contain indicators of illness and injury.
- Statistical presentations about children's health have taken the form of either profiles (i.e., sets of selected health statistics or indicators) or more recently, indexes. At present there is no one health index that summarizes the health status of children in the birth-through-teenage range. A few indexes, however, have been developed for age groups within this range, and some adult indexes may be appropriate for the older teenager.
- Health statistics for infants and young children are more readily available than those for school-age children and adolescents.
- In general, national-level profiles of children's health status and socioeconomic characteristics are more readily accessible to the general public than statewide or local profiles. Profiles have been compiled in several states (including Arkansas, Illinois, Kentucky, Maine, Massachusetts, and New York). Similarly, the Los Angeles County Health Plan for Children contains a very comprehensive child health profile. Although they are not updated on a regular basis, several of these profiles contain trend data. The state and local agencies and organizations that do regularly compile health profiles generally report on a very restricted number of health indicators for special planning, targeting, and/or policy development needs.

BACKGROUND INFORMATION ON CHILD HEALTH ISSUES

Butler, John; Starfield, Barbara; and Stenmark, Suzanne. "Child Health Policy." In H.W. Stephenson and A.E. Siegel, eds. Child Development Research and Social Policy. Chicago: University of Chicago Press, 1984.

The authors describe their chapter as follows: "We begin with a summary of vital statistics from recent decades and data on the epidemiology of childhood disorders, focusing especially on trends in childhood mortality, morbidity, the "new morbidity," and disability... . Then we examine the research evidence on four major topics: the determinants of child health and illness; the effects of illness on the development of children; patterns of access to health care in childhood and consequences of insufficient access; and the acquisition in childhood of health-related concepts, beliefs, attitudes, and behavior. The literature on each of these topics supports certain inferences of potential significance for policymakers. The third section describes the decision-making context of national child health policy, and then we briefly analyze several controversial issues...

They include: how further to improve pregnancy outcomes; how to respond to the problem of teen pregnancy; how to reduce the incidence of death and disability associated with motor vehicles; whether to strengthen the role of schools and pre-schools as sites of case finding and care; and how to define the public responsibility for the health care of chronically ill and handicapped children. The significance of each issue will have been made clear by information presented in earlier sections of the chapter.

The final section is devoted to discussion of research and data needs in support of child health policy, with particular attention to the need for better indicators of child wellness and functioning, improved policy-oriented epidemiology and outcome measurement to assess program impact, more research on the efficacy of psychosocial components of pediatric care, and policy research and training combining the insights of health professionals and others in the field of child development. These areas deserve concentrated effort in the years to come." [Authors, text]

Eberst, Richard M. "Defining Health: A Multidimensional Model." Journal of School Health, 54(3): 99-104, 1984.

This article describes a conceptual model of health that utilizes the analogy of a Rubik's cube. Six dimensions of health, corresponding to the sides of a cube, are identified as: physical, mental, vocational, emotional, spiritual and social. Each of the major dimensions contain subelements. For example, the physical dimension includes functional ability of each body system, fitness

level, metabolism, presence or absence of disease, presence or absence of predisposing risk factors, and others. Like the Rubik's cube, one's state of health is described as the synergistic relationship of the six sides or dimensions.

Factors that ultimately influence health status are described as either internal and external. Of the latter, those that are considered to be within the individual's control (such as cognitive processes, significant others, resources, affective processes, and political processes) are identified as potential targets for health education programs.

The author recommends that we consider health to be a complex construct although, unlike the solution to the cube in which all sides must be the same color, good health status can consist of a variety of different combinations of the subelements. Because a change in one dimension can precipitate a chain reaction of changes both beneficial and detrimental, health educators are warned that they should attempt to anticipate the potential consequences of their interventions.

Friedman, Stanford B., and Weiner, Irving. "Special Problems of Adolescents." In R.J. Haggerty, K.J. Roghmann, and I.B. Pless. Child Health and the Community. New York: John Wiley and Sons, 1975.

As part of their study of community health in Monroe County, New York, the authors of this chapter compiled information related to adolescent health. An analysis of reasons for hospital admissions for children 13-17 years old demonstrated that 18.8 percent were for childbirth (approximately half of the hospitalizations for all females in this age group), 11.9 percent for tonsillectomy and adenoidectomy, 44.2 percent for other surgery, and 25.1 percent for other medical care.

A survey of adolescents demonstrated the positive relationship of chronic physical illness and emotional problems. Together, the admissions data and survey findings support the authors' contentions that physical and behavioral problems of adolescents are sufficiently prevalent to merit more attention.

A survey of drug use among 7,400 high school students indicated that there was an unmet need for related services. Recognizing that adolescents will be served in both pediatric and adult clinic settings, the authors recommend that health professionals increase their awareness of adolescent needs. Similarly, health services need to be responsive to adolescents' special family and financial situations.

Janis, Juel. "Health Policy for Children." In E. Zigler, S. Kagan, and E. Klugman, eds. Children, Families, and Government: Perspectives on American Social Policy. Cambridge: Cambridge University Press, 1983.

This chapter traces the evolution of federal involvement in child health in terms of both policies and programs. The overview of federal child

health "policy" leads to consideration of the 1981 Report of the Select Panel for the Promotion of Child Health, Better Health for Our Children: A National Strategy, as a blueprint for child health policy for the next two decades. Key political factors that may influence the achievement of the panel's child health goals are described. They include reduced fiscal support for categorical and entitlement programs, administrative decentralization, decreased regulation and reporting requirements, and the competition for limited public and private funding. Within this context, several recommendations are provided for achieving national child health goals.

National Research Council, Assembly of Behavioral and Social Sciences, Advisory Committee on Child Development. Toward a National Policy for Children and Families. Washington, DC: U.S. Government Printing Office, 1976.

This report provides a framework for the development of a national policy for children (primarily under the age of six) and their families. The authors first describe the progressive changes in and fragmentation of the American family over the past 25 years. The impact on children of their families' social and economic conditions are discussed. The major causes and consequences of changing family conditions and socioeconomic factors are summarized with regard to the following: family economic resources, the health and health care of children, child care, and special services. Recommendations for change are addressed to a variety of public agencies, private institutions, and groups.

The report concludes with recommendations for regular and ongoing monitoring of the impact of government policies and programs on families and children. In addition, the following types of research are recommended: (1) studies of children and families in natural settings, (2) systematic experimentation with, and evaluation of, proposed programs for children and families, and (3) the development of social indicators for the child population.

Patrick, Donald, et al. "A Cross-Cultural Comparison of Health Status Values." American Journal of Public Health, 75 (12):1402-1407, 1985.

The extent to which the values attached to health status are similar in different cultures or social groups is important for understanding health and illness behaviors and for developing standardized health status measures. A cross-cultural study was conducted to compare the health status values obtained in a United States population (Seattle, Washington) with those from another English-speaking culture (London, England) on the Sickness Impact Profile, a standardized measure composed of 136 items. London judges rated the severity of dysfunction described in each item on an equal interval scale using the same methods of scaling and analysis employed in the Seattle study. A regression of English mean item values on U.S. mean values yielded a slope of 1.00 and an

intercept of -0.07, indicating that judges gave strikingly similar ratings to most items. Agreement was higher at the more severe end of the dysfunction continuum than at the least severe end, a finding consistent with the notion that what constitutes health is more difficult to define than what constitutes illness. While a universal conception of dysfunction may exist in English-speaking societies, the social and cultural determinants of health status values deserve more systematic study. [Authors]

Shonkoff, Jack P. "The Biological Substrate and Physical Health in Middle Childhood." In W.A. Collins, ed., Development During Middle Childhood: The Years from Six through Twelve. Washington, DC: National Academy Press, 1984.

This chapter provides an overview of the current research regarding health and illness during middle childhood. It reviews existing knowledge of the biological substrate of human function during this period. It also explores the problem of conceptualizing health and illness and analyzes it in the context of the child's emerging life-style and sense of his or her own health status both during the school years and in the future. An agenda for further study is proposed. [Author]

U.S. Department of Health and Human Services. Report of the Secretary's Task Force on Black and Minority Health. Washington, D.C.: U.S. Government Printing Office, 1985.

The report of the Task Force on Black and Minority Health contains an analysis and synthesis of information regarding the major factors that contribute to the health status of blacks, Hispanics, Asian/Pacific Islanders, and Native Americans.

The Task Force comprised senior officials and scientists representing the key federal programs that have an impact on black and minority health status. A primary concern of the task force was the significant difference between the mortality rate of these minority groups and that of the white population. A review of existing mortality indicators revealed that six causes of death accounted for more than 80 percent of the increased rate of mortality observed among blacks and the three other minority groups studied: cancer, cardiovascular disease and stroke, chemical dependency (measured by deaths due to cirrhosis), diabetes, homicide and accidents (unintentional injuries), and infant mortality. In addition to mortality data, the Task Force assessed morbidity and health status indicators. These included prevalence rates of selected chronic and infectious diseases, hospital admissions, physician visits, limitation of activity, and self-assessed health status. Demographic, social, and health systems characteristics were also reviewed.

Major findings and recommendations are presented in Volume I, the Executive Summary. All recommendations are consistent with the 1990 objectives for the Nation in disease prevention and health promotion. The task force identified the following six areas as priorities requiring immediate action in order to improve the health status of blacks and minorities:

- health information and education
- delivering and financing health services
- health professions development
- cooperative efforts with the non-Federal sector
- data development
- research

Additional volumes of the report contain the complete text prepared by subcommittees supporting findings and recommendations. The following volumes comprise the complete report:

1. Executive Summary
2. Crosscutting Issues in Minority Health: Perspectives on National Health; Data for Minorities; Minority Access to Health Care; Health Education and Information; Minority and Other Health Professionals Serving Minority Communities.
3. Cancer
4. Cardiovascular and Cerebrovascular Diseases
5. Homicide, Suicide, and Unintentional Injuries
6. Infant Mortality and Low Birthweight
7. Chemical Dependency, Diabetes
8. Hispanic Health Issues, Survey of the non-Federal community, Inventory of DHHS Program Efforts in Minority Health.

U.S. Department of Health and Human Services, Public Health Service. Promoting Health/Preventing Disease, Objectives for the Nation. Washington: U.S. Government Printing Office, Fall 1980.

This volume, Promoting Health/Preventing Disease, sets out some specific and quantifiable objectives necessary for the attainment of [the national goals established in the Surgeon General's Report on Health Promotion

and Disease Prevention, Healthy People (1979)]. Objectives are established for each of the 15 priority areas identified in the Surgeon General's report: high blood pressure control; family planning; pregnancy and infant health; immunization, sexually transmitted diseases; toxic agent control; occupational safety and health; accident prevention and injury control; fluoridation and dental health; surveillance misuse of alcohol and drugs; physical fitness and exercise; and control of stress and violent behavior. A number of different objectives are specified for each of the 15 areas. Taken together, the targets established in Promoting Health/Preventing Disease, when attained, should permit the realization of the overall national goals set down in the Surgeon General's report. [Authors, "Introduction and Overview"]

U.S. Select Panel. Better Health for Our Children: A National Strategy. The report of the Select Panel for the Promotion of Child Health to the U.S. Congress and Secretary of Health and Human Services. Washington, DC: U.S. Department of Health and Human Service, Office of the Assistant Secretary for Health and the Surgeon General, DHHS (PHS) Publication Number 79-55071, 1981.

The mandate of the Select Panel for the Promotion of Child Health was to develop "a comprehensive plan to promote the health of children and pregnant women." The report of the committee is contained in four volumes. Volume I presents the major findings and recommendations. Volume II contains specific recommendations for improving five major federal programs with significant impact on child health--Title V of the Social Security Act; the Special Supplemental Food Program for Women, Infants and Children; P.L. 94-142 -the Education for All Handicapped Children Act; Medicaid and EPSDT; and Community Mental Health Centers and Services Systems. Volume III is a comprehensive compilation of data on child health in the United States. Background papers are contained in Volume IV.

CHILD HEALTH INDICATORS AND HEALTH STATUS MEASURES

Adams-Taylor, Sharon; Fine, Amy; and Falk, Brenda. Selected Child Health Monitoring Efforts: Annual Survey 1984-1985. Washington DC: University of North Carolina, Child Health Outcomes Project, July 1985.

This report contains the findings of a survey conducted by the North Carolina Child Health Outcomes Project of innovative child health monitoring efforts throughout the United States. The purpose of the survey was to identify monitoring efforts involving the collection and dissemination of policy-relevant child health data on a selected set of twelve outcome indicators: infant mortality, low birth weight, births to teens, receipt of prenatal care, immunization status, growth stunting, iron deficiency anemia, elevated blood lead levels, child abuse and neglect, suicide, motor vehicle accident fatalities, and nonmotor vehicle accident fatalities.

The report contains three summary tables. Table I provides for each indicator a listing of the monitoring projects, data used, scope of the project, and data availability and format. Table II describes the monitoring projects cited in Table I, and Table III lists contacts for each project.

Brunswick, Ann F. "Health Services for Adolescents with Impairment, Disability, and/or Handicap: An Ecological Paradigm." Journal of Adolescent Health Care, 6:141-151, 1985.

"The purpose of this paper is to formulate a set of measures that can be used to monitor and evaluate health services for disabled adolescents. In attempting to meet this goal, two other objectives will also have been served: (1) the examination of the meaning of adolescent disability in functional terms; (2) the design of a framework that can guide the selection of services into a comprehensive community health program for disabled adolescents" (p. 141).

The conceptual framework contains four levels of influence on an adolescent's experience of disability: macrosystem, exosystem, microsystem, and ontosystem. These levels range from influences that are external to the adolescent (values, norms, general policy, and legislation) to biopsychosocial attributes of the individual. This design provides an efficient framework for classifying impairment and formulating an appropriate service system. Outcomes recommended for assessing community health services for adolescents at the ontosystem level include measures of mobility and independence; activity level; communication skills, social role performance and future role preparation; sense of competency and autonomy; feelings of worth and esteem; and health status. Process measures for evaluating service delivery include fragmentation of medical services; distance needed to travel to service sites; extent of ancillary services and physical supports used; attitudes, perceptions, and satisfaction regarding each of these services.

Brunswick, Ann F. "The Brunswick Adolescent Disorders Schedule." Unpublished.
New York: School of Public Health, Columbia University, 1983.

The Adolescent Disorders Schedule (ADS) is intended to standardize the information collected about adolescents' health. In this way it can serve as an analytic tool both for guiding adolescent health services and for monitoring secular changes in patterns of adolescent health problems. It has been designed around a biopsychosocial conceptualization of health. It is based on an integrated ecological perspective, identifying settings, conditions, and behaviors which are considered risks to health (present and/or future) as well as providing a means for classifying existing psychophysical health disorders, per se. Disorders have been conceptualized further around primary tasks and challenges common to the adolescent life period: rapid growth and change in physical, social, cognitive, and emotional spheres and the emergence of an individuated identity. Significant qualitative dimensions also are included for assessment of severity and treatment needs. This classification has been developed to capture special risks of inner-city, low-income, and minority adolescents, as well as other less deprived young people.

Brunswick, Ann F. "Health Stability and Change: A Study of Urban Black Youth." American Journal of Public Health, 70(5): 504-513, 1980.

Personal interviews were conducted with a representative sample of 536 urban black youths at two points in their life cycle: first, when they were adolescents, aged 12-17, and six to eight years later, when they were young adults, aged 18-23. A total of 47 health problems for males, and 48 for females, were inquired about each time. Longitudinal analysis was performed to determine the extent of change, and the direction of change. The health problems increased for both sexes, but the increase was significantly greater among males than females. Male and female morbidity count, thus, became nearly equivalent in young adulthood, whereas, in adolescence, young women's had exceeded men's. More detailed age analysis revealed that the greatest increase in male's health problems occurred two years behind that for women: for men, between ages 17 and 18; for women, between ages 15 and 16. With but few exceptions, the same health problems which dominated in adolescence continued to be most prevalent in young adulthood. Population prevalence rates, however, understate the considerable degree of shift or turnover in individual cases reporting health problems as well as in general health status as measured by the total number of those problems. [Author]

Brunswick, Ann F. "Indicators of Health Status in Adolescence." Institutional Journal of Health Services, 6(3): 475-487, 1976.

The study reported here is based on data obtained in 1968-1970 from a representative community sample of urban black youths in the United States aged

12-17 years, inclusive. Analysis is directed at conceptual and methodological issues in measuring health status. It suggests the need for greater attention to subjective self-evaluated and self-reported components of health status, specified here as "ontological" health. This is related to health and illness behavior generally, to utilization of health services more particularly. The case is made for a multiple-indicator approach to measuring health status as being more consistent with the multidimensional phenomenon to which it refers. The method used in this study for deriving a composite health status index from four component self-reported indicators is described. The distribution of the sample on this composite was used to identify self-reported health conditions that warrant attention from providers of adolescent health services. Since subjective evaluations influence experienced severity of health problems, the health status composite index was applied in this study as a means of discriminating differential seriousness in self-reported health problems. Finally, some differences between indicators of "ontological" health and "medical" health also are analyzed for commonalities and differences between them. [Author]

Chan, Linda; Portnoy, Bernard; and Black, Robert. "California's Use of Health Statistics in Child Health Planning." American Journal of Preventive Medicine, 1(2):24-30, 1985.

The California Health Plan for Children, 1979, compiled by the Committee on Health Planning of California, District IX of the American Academy of Pediatrics, is an extensive report on health problems unique to the children of California. Since its publication, many local and state health agencies have been using it as a guide and source of data in their planning efforts for child and youth health.

The creation of the plan demonstrated a successful working relationship between health care practitioners and biostatisticians, the acceptance by health professionals of the use of health statistics in planning, the different uses of health statistics in formulating recommendations, and an approach to organizing and summarizing large bodies of data. Nevertheless, our experience indicates that although collection systems for data on population, mortality, natality, morbidity, and health services statistics abound, their use in community health planning for subpopulations is still limited by problems in the definition, validity, and completeness of the data elements. The establishment of an individualized data system for the entire population, to be developed, coordinated, and controlled by one central agency, could be a significant step toward solving these long-standing problems in our data systems. [Authors]

Three criteria guided the selection of health indicators: the validity of the indicator as a measure of achievement of one or more of the committee's nine goals; the relative value of the indicator; and the availability of data necessary to derive the indicator.

A total of 105 health status indicators were identified and categorized as follows:

- population data - including subpopulations defined by age, sex, geographic area, ethnicity, socioeconomic level, and mobility.
- mortality data - fetal, neonatal, perinatal, and disease specific mortality rates (from infectious diseases, preventable diseases, congenital anomalies, birth trauma and injuries, pregnancy complications, accidental causes).
- natality data - mother's age, prenatal care, out-of-hospital birth, gestational age, birth weight, type of delivery, birth injury, pregnancy complication, use of alcohol, drugs, or tobacco during pregnancy, and legitimacy.
- health systems indicators - provider-to-population ratio (i.e., physicians, nurses, dentists, and beds) and overall utilization rates such as hospitalization, births, and outpatient visits.

Culyer, A.J., ed. Health Indicators: An International Study for the European Science Foundation. New York: St. Martin's Press, 1983.

This book is the product of a series of three workshops held at the University of York in 1979-81. The workshops (chaired by the editor) were established by the British Social Science Research Council at the initiative of the European Science Foundation with the aims of providing a synthetic account of European research to date in the field of health indicators, to assess current research needs and to make suggestions both about future directions of research in Europe and about its organization....

It is hoped, therefore, to have provided a source book that will not only introduce those who are unfamiliar with it to the field but also indicate the directions taken, problems tackled, and solutions to practical problems offered by current research in health indicators.... The contributed chapters constitute detailed reviews of various aspects of current research. The conclusions in the final chapter are so framed as to lead to recommendations about both research directions and research organizations. [Author, "Preface"]

Eisen, Marvin; Ware, John E; Donald, Cathy; and Brook, Robert. "Measuring Components of Children's Health Status." Medical Care, 17(9): 902-921, 1979.

Measures of physical, mental, and social components of health status and general health ratings were studied for children aged 0-4 (N=679) and 5-13 (N=1,473). Questionnaires were completed by adult proxies (usually mothers) in

three generally healthy populations. Hypothesized multi-item scales were tested; reliability was estimated and preliminary attempts at validation were undertaken. Items in ten scales pertaining to mental health (Anxiety, Depression, Positive Well-Being, Mental Health Index), social health (Social Relations), general health ratings (Current Health, Prior Health, Resistance/Susceptibility to Illness, General Health Rating Index), as well as parental satisfaction with child development satisfied Likert-type and discriminant validity criteria. Because functional limitation items were endorsed for very few children, scales to measure physical health could not be tested. Almost all scales were sufficiently reliable for group comparisons; reliability coefficients were lower in the most disadvantaged population. Interrelationships among scales and validity variables generally supported their construct validity and supported a multi-component model of children's health status. [Authors]

Elinson, Jack. "Toward Sociomedical Health Indicators." Social Indicators Research, 1:59-71, 1974.

The various forms of mortality data and biomedical measures of morbidity have become inadequate measures of the level of health in economically developed countries. Measures of functional physical capacity have some advantages but do not reflect physical impairment. Current attempts to develop sociomedical health indicators include: measures of social disability; typologies of presenting symptoms, which have been used to estimate probable needs for care; measures which focus on behavioral expressions of sickness; research based on operational definitions of "positive mental health," "happiness," and perceived quality of life; assessments of met and unmet needs for health care, which are measures of social capacity to care for the sick.

Sociomedical indicators reflect both objective conditions and social values. They are policy-oriented, serving as mobilizing agents for sociopolitical pressures concerned with raising the overall level of health of the population. [Author]

Green, Lawrence; Wilson, Ronald; and Bauer, Katherine. "Data Requirements to Measure Progress on the Objectives for the Nation in Health Promotion and Disease Prevention." American Journal of Public Health, 73(1): 18-24, 1983.

The Reagan Administration has adopted the policy guidelines developed over the previous few years in the disease prevention and health promotion initiative of the Carter Administration. Broad national consensus had been sought in the formulation of 226 measurable objectives for the decade. We classify the prevention objectives according to their position in an implied causal chain: (1) improved programs, (2) increased public and professional awareness, (3) reduced risk factors, and (4) improved health status. Prior to

1980, the data systems and periodic surveys sponsored by federal agencies and national organizations covered only four of the 42 objectives in the public and professional awareness category, whereas at least half of the objectives in each of the other three categories were covered by available national data sources, mostly federal. Sample surveys are needed to measure the majority of the currently unmeasured objectives in all four categories. Private and state health interview surveys are needed to supplement the federal capacity, especially in the face of federal cutbacks in survey capacity. [Authors]

Green, Lawrence W. "Some Challenges to Health Services Research on Children and the Elderly." Health Services Research, 19(6 Part III): 793-815, 1985.

Imposing models and methods from the mainstream of health services research on the needs of children and the elderly runs several risks of misplaced emphasis. The risks may be greater in disease prevention and health promotion than in medical care, because more people are affected and the errors take longer to discover. One of the principle risks is insisting on health outcome measures when the more significant measures of success for health promotion in both of these target populations may be cognitive, developmental and behavioral changes. The author uses children as the initial reference point to explain his concern and to develop the challenge which he places before the health services community. He then illustrates some of the ways in which the same concerns apply to the elderly. [Clearinghouse on Health Indexes]

Kleinman, Joel C. "Mortality." Statistical Notes for Health Planners, National Center for Health Statistics, 3, February 1977.

Deaths are the oldest measure of health status. However, when death statistics are used to describe the health status of an area they tell only part of the picture, since many nonfatal conditions cause considerable illness and disability. The article, however, notes that mortality data can be useful in identifying communities and populations with special needs for preventive or primary care services.

The article discusses overall mortality. The crude death rate (CDR) is defined, and limitations of comparing different geographic areas using CDRs are discussed. Summary mortality indexes are offered as one way of overcoming this problem. Three mortality indexes are described in an appendix to the article.

The article also discusses sources of mortality data, uses of mortality data for planning, and limitations of the data.

Klerman, Lorraine, and Rosenbach, Margo. Need Indicators in Maternal and Child Health Planning. Waltham, Mass.: Florence Heller Graduate School for Advanced Studies in Social Welfare, 1984.

This manual describes a procedure for developing indicators that states could use to meet the requirements of the MCH Services Block Grant: to identify populations and localities in need of MCH services and to provide a fair method of allocating funds to them....

The authors' decision about the methods to be used in developing the need indicators was guided by two reviews. The first was an examination of the literature on need assessment. This is described in the unpublished Final Report, which is available from the DMCH. The second was an analysis of the techniques which states and other agencies are using, or have used, to assess need. These are summarized in this manual's Chapter 2. Chapters 3 and 4 describe the steps a state would take in order to derive the need indicators. Chapter 5 suggests how states could use the need indicators to make decisions about resource allocations.

The county is the geographic unit of analysis for the needs assessment. Four separate indicators of high risk for MCH problems are based on the needs of mothers and infants; preschool and school-age children (ages 1-14); and adolescents. The reproductive and non-reproductive needs of adolescents are considered separately. Both health and socioeconomic risk indicators are used, but they are used separately because results of an analysis indicate that they represent different dimensions.

The needs assessment manual also describes how to prepare an inventory of health care resources by area that should accompany the risk indicators. Resources to be documented should include public and private providers and inpatient and ambulatory services. [Authors, p. 3, and summary of pp. 17-21]

Klerman, Lorraine; Weitzman, Michael; Alpert, Joel; and Lamb, George. "School Absence: Can It Be Used to Monitor Child Health?" In D. Walker and J. Richmond, eds. Monitoring Child Health in the United States. Cambridge: Harvard University Press, 1984.

This paper will attempt to answer the question, "Can a measure of school absence be used to monitor the outcome of child health policies and programs?" It will suggest that the answer depends on the level of intervention to be monitored. If the purpose of the indicator is to monitor the effects of macro-level policies and program changes, such as changes in Medicaid funding for maternal and child health care, reductions in children's nutritional programs, or even AFDC cutbacks and high levels of unemployment, then school absentee measures are not applicable.

If, however, the purpose is to study the effect of a specific program or policy on the individuals who are targeted by this program or policy, school attendance is a measure which should be considered. For example, programs for pregnant and parenting adolescents should and do use school attendance as an outcome measure. So should programs which are concerned with the care of chronic illness in children, the influence of primary care or counseling for depression, or treatment of alcohol or drug abuse in children or their parents.

In addition, rates of school absence may be useful at an intermediary level between macro-level policy and individually oriented programs. This level if compared with rates during an earlier period or with rates at another school, may be a sensitive indicator of neighborhood health problems (assuming it is a neighborhood school rather than one whose students are bused in), or of the success or failure of a school-based program, such as the Adolescent School Health Program (ASHP), for which the authors are responsible....

This paper will first examine the factors limiting the usefulness of school absence as an indicator of the effect of national or community policies, or even in less global studies. Then it will review the advantages of this measure for both research and clinical purposes. [Authors, "Introduction"]

Klerman, Lorraine. Research Priorities in Maternal and Child Health: Report of a Conference Sponsored by the Florence Heller School for Advanced Studies in Social Welfare, Brandeis University, and the Office for Maternal and Child Health, Health Services Administration, Public Health Service, U.S. Department of Health and Human Services, June 9 and 10, 1981.

This volume is a compendium of papers delivered at a conference held in June 1981 for the purpose of reviewing the research priorities of the Office for Maternal and Child Health (Health Services Administration, Public Health Service, U.S. Department of Health and Human Services). Recommendations regarding research priorities were categorized as follows: central themes in maternal and child health; research specific to each of four population groups (women with fertility-related needs, preschool children, school-age and adolescents, and children with special needs); and suggestions for the organization and administration of the OMCH. Among the concerns pertaining to improving research methods it was suggested that "new indicators of health status are needed since the classic outcome measures of morbidity and mortality have limited applicability in the United States today" [Author, p. 5]

Kovar, Mary Grace. "Some Indicators of Health Related Behavior Among Adolescents in the United States." Public Health Reports, 94(2):109-117, 1979.

The purpose of this paper is to present baseline data on indicators of health-related behavior among adolescents. The following three criteria were used for the selection of these indicators: (1) the health-related behavior is

the subject of legislative or other public debate; (2) these behaviors have a high probability of adverse health consequences; and (3) they are based on national data that could be tabulated for the age groups 12-17 years.

The data are derived from a variety of national studies. The categories used to organize these data and the types of measures presented are as follows:

- Substance Use
 - trends related to use (ever) of drugs, alcohol, or cigarettes
 - extent of use of drugs, alcohol, and cigarettes
- Sexual activity and its consequences
 - percentage of unmarried adolescent girls that have had sexual intercourse
 - birth rates by age of mother
 - abortion rates
 - contraceptive use
 - case rates of sexually transmitted diseases
- Illness, Use of Medical Services, Death
 - number of acute conditions per year
 - number of days of restricted activity per year
 - number of days in bed because of ill health
 - number of missed days of school
 - days of hospitalization and principal diagnosis
 - death rates for all causes and for specific causes

Kovar concludes that although the health of adolescents is good as measured by conventional indicators, the data show that many adolescents engage in behaviors that place them at risk of disease or disability either in the short run or in the future.

Miller, C. Arden; Fine, Amy; Adams-Taylor, Sharon; and Schorr, Lisbeth. Monitoring Children's Health: Key Indicators. Washington, D.C.: American Public Health Association, 1986.

This book is based on the belief that maternal and child health policies and programs can be improved through better use of health outcome data. Twelve indicators were selected on the basis of their health and policy significance. Each indicator is fully described with the following information: definition, exact indicator(s) used, policy and health implications, current status and trends, risk factors, 1990 U.S. objective, data sources (national, state, and local), data needs and gaps.

The indicators include the following:

Newborns and Infants

- inadequate prenatal care
- low birth weight infants
- infant mortality rate

Children

- inadequate immunization status
- population-based growth stunting
- elevated blood lead levels
- non-motor-vehicle accident fatalities

Adolescents and Young Adults

- births to school-age mothers
- suicides
- motor vehicle accident fatalities

All Ages

- iron deficiency anemia
- child abuse and neglect

[Authors]

Morton, Jean, and Guendelman, Sylvia. New Perspectives on Monitoring Child and Adolescent Health. Berkeley, Cal.: Department of Maternal and Child Health, University of California at Berkeley, 1985.

This monograph is based on the proceedings of an Interdisciplinary Maternal and Child Health Institute held on the Berkeley campus in June 1984. Attending the continuing education program were social workers, nurses, and nutritionists from DHHS Regions VII, VIII, IX, and X; the majority were state-level Maternal and Child Health/Crippled Children (MCH/CC) consultants.

The new perspectives to which the title of this monograph refers are the principal factors which guided the formulation of the program for the Multidisciplinary Institute and the selection of papers for the publication. The Planning Committee incorporated three perspectives: emphasis on measures of child health outcome rather than process; utilization of child health outcomes as the focal point for planning, evaluation, and advocacy; and the introduction or expansion of psychosocial measures.

Child health outcomes measure the health status or conditions of consumers, patients, or population groups as contrasted to process measures, which are encounter data such as clinic visits, services, or specific interventions given by a provider. Utilizing child health outcome measures as the focus for planning and change means selecting a particular health status or condition that needs improvement and organizing resources--dollars, people, and services--to achieve that outcome. Psychosocial measures reflect the social, emotional,

and behavioral components of health and health care. The challenge is to make more explicit psychosocial process measures that contribute to the more traditional and biologically oriented outcomes and to define key psychosocial outcomes that can be used in monitoring systems.

The three themes are interwoven throughout the papers. Organizationally, the papers are grouped according to specified topics. The first section focuses on monitoring child and adolescent health. The second section, on psychosocial components of monitoring, explores the expansion of psychosocial indicators as a means of more accurately describing the changing health profile of children, both in monitoring systems and in research. It also offers a valuable compendium of sources of psychosocial data. The multiple uses of data are developed in the final section, which offers strategies and approaches that have successfully used data in state and county planning, the securing of legislative support, block grant allocation, program planning, community advocacy, and quality assurance. [Authors, Adapted from the "Preface" and "Introduction"]

National Center for Health Statistics. Health Statistics Today and Tomorrow. Vital and Health Statistics, Series 4, No. 15 (HRA), DHEW Publication No. 74-1452. Department of Health, Education, and Welfare, September 1973.

This report sets forth the major findings and recommendations of the Committee to Evaluate the National Center for Health, the current status of health statistics, and the problems existing today. It continues with future needs in health statistics. Forecasting the shape of things to come, the Committee's recommendations are presented in Chapter IV. Certain general recommendations are followed by technical recommendations, more specific in nature. The latter are grouped in four broad categories: Program Development, Methodology, Management and Operation, and Publications and Other Data Access. [Authors, "Foreword" and "Introduction"]

Norem, Rosalie, and Brown, W. Christine, "Family Health Status Indicators." Paper presented at the Annual Meeting of the National Council on Family Relations, St. Paul, Minn., October 14, 1983.

This paper describes the development and testing of a measure of family health status. The instrument is seen as a first step in assessing the usefulness of health status as an outcome measure in family stress research. The paper will discuss the relative merit of each of the indicators of family health status tested, the relationships among those indicators, the relationships among the health status of family members and implications for continued use of family health status as an important construct in family stress research. [Authors]

Olsen, Marvin E.; Canan, Penelope; and Hennessy, Michael. "A Value-Based Community Assessment Process: Integrating Quality of Life and Social Impact Studies." Sociological Methods and Research, 13(3):325-361, 1985.

It is argued that community quality of life and social impact studies are similar in nature and can be integrated with a common analytical model for conducting community assessments. All such assessments must incorporate the basic values prevailing in the community, as expressed by community leaders and various segments of the population. Community assessments must also include both objective and subjective procedures, as neither approach is meaningful by itself. The initial stages of the proposed community assessment process are illustrated with research conducted on the island of Molokai in Hawaii. That study mapped the value structure of the island's residents, from which social indicators for the island were derived. [Authors]

Omenn, Gilbert. "Maternal and Child Health: Use of Health Status Indicators in Coordinating and Targeting Federal Programs." Journal of Community Health, 7(3):194-210, 1982.

The United States has achieved dramatic improvements in overall maternal and child health status, yet faces disturbingly wide variations in the health status of many population subgroups. The Surgeon General in 1980 published specific quantitative objectives to stimulate further improvements in the health of the American people by 1990. A critical step in meeting relevant objectives is the more effective use at national, state, and local levels of available data, particularly infant, perinatal, neonatal, and maternal mortality rates and the incidence of low-weight births. This paper reviews variations in infant mortality rates and five current federal "categorical" programs that aim to improve maternal and child health: Supplemental Feeding Program for Women, Infants, and Children; Head Start; Maternal and Child Health; Family Planning; and Community Health Centers. Several examples are cited of effective use of data in the coordination and targeting of resources from these large public programs. Recommendations are made for enhancement of federal maternal and child health programs within current funding levels. These recommendations will be all the more relevant if the Congress enacts block grants to the states with lower total funding. [Author]

Roughmann, Klaus. "Child Health Statistics." In R.J. Haggerty, K.J. Roughmann, and I.B. Pless. Child Health and the Community. New York: John Wiley and Sons, 1975.

The author describes birth, death, and communicable disease statistics for Monroe County, New York. The limitations of county-level data include lack of accuracy, changing definitions, unreliability, and confusion about social/ethnic classification. The author recommends that one way to overcome the problem of instability of rates when events are relatively rare is to aggregate figures over longer timeframes or larger geographic areas.

Russell, Louise B. Is Prevention Better Than Cure? Washington, D.C.: Brookings Institution, November 1984.

This study about evaluating prevention serves two major purposes: to review the facts about some important preventive measures and the results of careful evaluations of these measures; and to describe, promote, and help improve the principles on which the evaluations are based. While the evaluation of prevention has much in common with the evaluation of other investments, it also involves some special and interesting difficulties: how to represent health benefits; the difficulties of tracing through the sometimes complicated chain of events from prevention to health effects; the particular importance of timing for the assessment of preventive care; and more. These issues are brought up in the context of the preventive measures that illustrate them best. [Author]

Siegmann, Athalia E., and Elinson, Jack. "Newer Sociomedical Health Indicators: Implications for Evaluation of Health Services." Medical Care, XV (5, Supplement): 84-92, 1977.

The purpose of this article is to discuss sociomedical health indicators that can augment or replace traditional biomedical indicators for assessing the effectiveness of health services in maintaining and improving the health of the population. The authors argue that the impact of medical care cannot be inferred from any association with death rates or undifferentiated morbidity measures. Health indicators that reflect our notions of health and the predominant patterns of health problems (i.e., chronic disorders) are needed.

The following types of sociomedical health indicators are described as examples of more useful health status measures:

- Measures of disability and discomfort as included in the population-based National Health Interview Survey.
- Activities of Daily Living Index - to measure primary sociobiological functions particularly for the chronically ill.
- Sickness Impact Profile - containing 300 outcome measures in 14 behavioral categories.
- Reproductive Efficiency Index - to measure the percentage of pregnancies that succeed in producing normal surviving children. The index replaces a single measure (infant mortality) with a summary measure.
- Measures of unmet need - although not considered to be health status indicators, scales of unmet need are suggested as legitimate measures of program outcome.

Starfield, Barbara, and Budetti, Peter. "Child Health Status and Risk Factors." Health Services Research, 19(6 Part II): 817-886, 1985.

In this article, the authors review the usefulness of information on children's health status and risk factors which are available from existing data bases and propose a research agenda which calls for a change of focus from specific diseases to people themselves. According to this agenda, research toward understanding the demand for health care resources must incorporate three themes. The first is the development and application of generic measures of morbidity. The second is the development of a means for tracking the health of individuals in populations. And, third, the development and application of better methods to examine the impact of medical care on functional status and its effectiveness in preventing future morbidity and disability. [Clearinghouse on Health Indexes]

U.S. Department of Health and Human Services. Maternal and Child Health and Crippled Children Services: Inventory of Data Sources. Washington, D.C.: U.S. Public Health Service, Health Resources and Services Administration Bureau of Health Care Delivery and Assistance, Division of Maternal and Child Health, 1984.

This sourcebook describes sixty-one national maternal and child health data bases containing information that is collected regularly and periodically and that is available to users outside of the sponsoring organization. The following information is provided for each source of data: type of data (e.g., demographic, health status, morbidity, etc.); client descriptors; geographic division; periodicity, currency, time series; collection methodology and reporting; funding source; availability; publications; and synopsis.

Stressing that complete and reliable information is needed for program planning, policy development, monitoring and evaluation, the authors cite a number of serious limitations in the data sources included in the inventory:

- narrow focus (limited to particular target populations or issues)
- incomparability of data sources
- uncertainties about future funding (raising questions of quality and periodicity)
- inadequate documentation (making it difficult to assess reliability, validity, and comparability of the data)
- diversity of reporting periods

Walker, Deborah Klein, and Richmond, Julius B. Monitoring Child Health in the United States. Cambridge: Harvard University Press, 1984.

In order to track child health in America over the next two decades, we need to know what indicators should be applied or need to be developed to give us the information necessary to observe trends. These trends need to be followed at several levels of policy analysis--national, state, and local community. Furthermore, the relationship between the knowledge of these trends and the ability of each child to realize his or her greatest potentialities must also be clear.

Recognizing the need for better monitoring of child health status, the Working Group on Early Life and Adolescent Health Policy of the Division of Health Policy Research and Education of Harvard University convened a small group of child health experts to discuss the issues surrounding the design and implementation of an adequate child health monitoring system in the United States. This book was written from the set of papers and discussion comments presented at this Workshop. The purpose of the book is to define and discuss some of the major issues and policies surrounding the determination of the best set of child health indicators which can be used to monitor child health outcomes for policy and program planning purposes. The book includes discussions of selected issues and policies in the following areas: current monitoring efforts in the field and their use of child health outcomes, population-based data available to study child health status and use of services, promising lines of ongoing research on children and families which might be used to generate indicators for future monitoring systems, and new strategies for looking at the traditional health indicators (e.g., infant mortality, height and growth measures), design issues key to linking program and policy changes to child health indicators, and social strategies and political realities necessary for the implementation of an adequate monitoring system in the United States. Although the emphasis is placed on a monitoring system which can assess longer-term trends, indicators which will be responsive to short-term developments and shifts in the nature or support of child health programs are also considered of interest and discussed throughout the chapters.

The book assumes the broader view of child health, which we believe is that of child health workers generally; this perspective considers all aspects of the child's functioning, including psychological, social, and intellectual development. Thus, indicators of child health status must reflect the World Health Organization's (1978) comprehensive view of health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity." [Authors, Chapter I, "Introduction"]

Wallace, Helen M., and Smith, Jack C. "Monitoring the Effects of Budgetary Reductions on the Health Status and Health Care of Mothers and Children: A Preliminary Protocol." Clinical Pediatrics, 21(7):421-423, 1982.

The authors describe a plan for monitoring the effect of budgetary reductions in California on the Maternal and Child Health (MCH) field. The

following three areas were targeted for monitoring, and suggested elements within these areas were named:

- Health Status of Mothers and Children

Mortality - maternal, fetal, perinatal, infant, neonatal, post-neonatal mortality rates, and mortality rates for children 1-19 years of age in five-year intervals.

Morbidity - incidence of communicable diseases, incidence of anemia, decayed, missing, filled teeth for dental status, activity limitation, disability days, reports of "fair or poor health," measurements of height and weight, reproductive outcome (including incidence of low birth weight, incidence of congenital malformations or birth injury, complications of pregnancy, labor and delivery, incidence of out-of-wedlock pregnancy, and adolescent fertility rate).

- Utilization of Health Services - including number of people seen by physicians and dentists annually, regular source of care, percent hospitalized, days of hospital stay, immunization levels, prenatal care (none, late, or early), births unattended by a professional, family planning, and services coverage.
- Provision of Health Services - including information on budgets, staff, caseloads, and patient attendance of agencies such as state and local health departments, hospitals, centers for handicapped children, neighborhood health centers.

The authors suggest that similar efforts are applicable to other states that have been affected by state and federal budget reductions. Moreover, they note that federal cutbacks curtailing several national health studies will have detrimental effects for the evaluation of MCH trends.

Ware, John E.; Brook, Robert H.; Davies, Allyson R.; et al. "Choosing Measures of Health Status for Individuals in General Populations." American Journal of Public Health, 71(6):620-625, 1981.

This paper offers suggestions to aid the selection of appropriate instruments and data gathering methods for studies that require measures of personal health status applicable in general populations. Before selecting measures, the reason for studying health status must be identified. Next, definitional issues arise when attempting to specify the components of health that are to be studied. Evidence supports restriction of the definition of personal health status to its physical and mental components, rather than

including social circumstances as well. In evaluating the suitability of available measures, three features must be considered: (1) practicality in terms of administration, respondent burden, and analysis; (2) reliability in terms of the study design and group or individual comparisons; (3) validity, in terms of providing information about the particular health components of interest to the study. Evaluating validity will be difficult for most available measures; careful attention to item content will be helpful in choosing appropriate measures. Despite problems in development and interpretation, overall health status indicators will prove useful to many studies and should be considered, as should both subjective and objective measures of health status. Given that the reasons to measure health have been identified, the aspects of health to be measured specified, and attention paid to their suitability, appropriate measures may often be found among those now available. [Authors]

Wilson, Ronald W., and Drury, Thomas F. "Interpreting Trends in Illness and Disability: Health Statistics and Health Status." Annual Review of Public Health, 5:83-106, 1984.

This paper... indicate[s] the methodological and conceptual issues that must be addressed when using available national data. Significant trends can be found when the data are disaggregated by age, sex, and other demographic variables, and when the issues presented in this paper are taken into consideration. These include a better understanding of methodological issues, such as questionnaire wording and examination methods, coding and editing procedures, definitions, as well as the context in which questions were asked. Conceptual issues include a knowledge of what is being measured, and what external factors other than actual health status can have an influence on the health measures, such as the levels of the use of medical services and other social and economic factors.

The national data systems of the National Center for Health Statistics provide a major resource for health researchers who are willing to overcome many of the inherent difficulties in these data. The increasing costs of collecting health data make it imperative that innovative analysis be applied to existing data bases. [Author]

Wilson, Ronald W. "Do Health Indicators Spell Health?" American Journal of Public Health, 71(5):461-463, 1981.

In this editorial the author addresses some of the factors related to the inability of health statistics to reflect health status. A key shortcoming of disability and illness statistics is that they may be influenced by medical intervention or factors such as implementation of national programs. For example, the implementation of Medicaid increased the use of health care by the poor, and consequently reports of disability increased.

Increases in reported prevalence of chronic diseases may be due to change in access, reduction in mortality, and/or earlier diagnosis due to improved technologies. Likewise, disability may be a function of reduced mortality. An artifact of improvements in survey methodology may also lead to increases in reported levels of disability and illness.

Efforts to develop more sensitive measures of health status include work on measures of functional ability or ability to perform routine activities of daily living. Researchers are also trying to classify people by health status instead of by enumerating events (e.g., the proportion of people with more than a certain number of bed-days per year is reported instead of the average number of bed-days per person). The demand for health indicators will grow with the need of health planners to create new services and evaluate existing services.

Zill, Nicholas; Sigal, Heidi; and Brim, Orville. "Development of Childhood Social Indicators." In E. Zigler; S. Kagan; and E. Klugman. Children, Families, and Government: Perspectives on American Social Policy. Cambridge: Cambridge University Press, 1983.

This chapter provides an excellent comprehensive overview of the social indicators movement and recent efforts to develop indicators about children. Available data on physical health, educational achievement, and social behavior and emotional well being are identified, as are several national and statewide statistical reports on the "state of the child" that utilize such data. The use of surveys of children and youth in the development of new indicators is followed by a discussion of the advantages and limitations of surveys used for this purpose. The chapter closes with a discussion of the usefulness of childhood indicators in monitoring progress or deterioration in child welfare, assessing the validity of popular beliefs about children and youth, as well as guiding the efforts of advocates and policymakers. Recommendations for improving the quality and usefulness of data on children are made.

Zill, Nicholas; Peterson, James; Moore, Kristin; and Hernandez, Donald. National Statistics on Children, Youth, and their Families: A Guide to Federal Data Programs. Washington DC.: Child Trends, Inc., 1984.

....The purpose of this compendium is to bring together in one volume, brief descriptions of a number of data collection programs supported by the federal government that provide statistical information on children and their families.

....The data collection programs described in this compendium are grouped into seven substantive headings: Population, Family Structure, Housing; Income, Expenditures, and Program Participation; Employment and Child Care; Health and Nutrition; Education; Social Behavior, Attitudes, and Substance Use; and Crime, Delinquency, Child Abuse. [Authors, "Introduction"]

CHILD HEALTH PROFILES

Bureau of the Census, U.S. Department of Commerce. Characteristics of American Children and Youth, 1980. (Current population reports, Special Studies, Series P-23, No. 114). Washington D.C.; U.S. Government Printing Office, 1982.

This report presents a statistical portrait of the demographic, social, and economic characteristics of American children and youth. Data are compiled from U.S. Government sources: surveys, decennial censuses, and vital statistics. The majority of the data have been published previously in Bureau of the Census or other governmental reports but are consolidated in this report to provide a readily accessible and comprehensive set of data on children and youth.

The report focuses on the characteristics of persons under 25 years of age. In general, "children" are defined as persons under 14 years old, and "youth", as persons 14 to 24 years old. Exceptions to these age divisions sometime occur in this report because of data restrictions by age.

The analysis trace changes among children and youth in the areas of population growth and distribution, migration, education, family and marital status, living arrangements, fertility, mortality and health, labor force participation, occupation, income and poverty status, voting, and crime victimization.

Some historical perspective on the current socioeconomic conditions of American children and youth is also provided in the report. Selected topics are examined in time series beginning with 1950; trend data for other subjects are shown for a more recent time span. [Authors: "Introduction"]

Children's Defense Fund. Black and White Children in America: Key Facts. Washington, D.C.: Children's Defense Fund, 1985.

This report describes the overall and comparative status of black and white children in America. Part One of this two-part book contains statistics and five year trend data regarding population size, family composition and income, employment, housing, child welfare, health, and juvenile justice. An overview of the Children's Survival Bill is also included. Part two includes detailed tables supporting the conclusions presented in the text. Additional tables and a glossary are located in an appendix.

Children's Defense Fund. American Children and Their Families: Key Facts. Washington, DC: Children's Defense Fund, 1982.

This reference book contains facts and data from the Census Bureau and other government sources. Data are categorized into the following topics: Children and Families, Income and Poverty, Working Parents and their Children, Vital Statistics, Child Care, Maternal and Child Health, Education, Housing, Juvenile Justice, Food and Nutrition, and Youth Employment. Key findings are highlighted in brief narratives accompanied by statistical tables.

Child health data include:

- infant mortality (by race)
- receipt of prenatal care (by age and race)
- access to a regular source of health care
- proportion of preschool children immunized against rubella, diphtheria, polio, and DPT
- participation in WIC, school lunch, and food stamps
- number of births to teenage mothers

Hughes Dana; Johnson, Kay; Simons, Janet; and Rosenbaum, Sara. Maternal and Child Health Data Book: The Health of America's Children. Washington D.C.: Children's Defense Fund, 1986.

The Data Book provides information concerning factors affecting the well-being of infants. Statistical tables, maps, graphs, charts, and narrative are used to describe national and state level trends.

The data detailed include:

- infant mortality rates
- low-birth-weight births
- births to teens
- out-of-wedlock births
- birth outcome disparities between races
- prenatal care utilization

Also documented are state's progress toward the U.S. General's maternal and infant health objectives for 1990.

Garell, Dale, et al. A Profile of Child and Adolescent Health Status and Needs, Volume II of the Child and Adolescent Health Plan. Los Angeles County: Department of Health Services, 1984.

This second volume of the Child and Adolescent Health (CAH) Plan presents data which can be used to describe the health status and health care needs of children and adolescents in Los Angeles County. It is hoped that by documenting the health status of children and adolescents, the need for new programs can be logically proposed and program effectiveness measured.

Two approaches were principally used for this presentation. First, selected demographic characteristics and health status indicators were reviewed as related to each of the Plan's nine goals (see Volume I for an explanation of the goals). Second, surveys were used to assess health care needs and to assist in evaluation of the overall organization and delivery of health services in Los Angeles County to the target population....

A summary of the data is presented first, followed by a description of the planning process used to select data for the CAH Plan. Limitations in the available data are mentioned. Recommendations for improvement in data collection, and proposals for program development are also included. [Authors, "Overview"]

Kovar, Mary Grace. "Children and Youth: Health Status and Use of Health Services." Health United States, 1978. (DHEW Publication No. [PHS] 78-1232, Public Health Service). Washington D.C.: U.S. Government Printing Office, 1978.

In this chapter, Kovar describes the physical health status of children in the United States and children's use of medical services. Statistics were drawn from data collection systems of the National Center for Health Statistics as well as other ongoing data collection systems and recently published special studies.

Kovar discusses the social context of children's health status and use of medical care, providing information on associated demographic data such as race, income, single-parent families, and geographic location. Conditions surrounding childbirth are also addressed as part of the discussion of social factors related to health status.

Health status is presented in terms of a broad range of incidence and prevalence statistics, as well as mortality and disability statistics. Use of medical services is also addressed in terms of site and frequency of ambulatory care and reasons for hospitalization. Kovar concludes her chapter with a discussion of the fiscal and geographic accessibility of health resources including physician distribution, public and private health insurance coverage, and federal programs (i.e., SSI, Medicaid, CHAMPUS, EPSDT, and others).

Lash, Trude, and Sigal, Heidi. State of the Child: New York City. New York: Foundation for Child Development, 1976.

This report presents data on measures considered to reflect the aspects of the lives of New York City children that are of greatest concern: health, education, family stability, safety, and protection of children when families cannot provide it. Data about these concerns were compiled from existing sources. The following are among the limitations of these data (which are primarily compiled to meet the monitoring needs of individual agencies): narrowness of scope; obsolescence and poor quality of the data; different geographical areas used for data sets (which limits one's ability to develop a comprehensive picture of an area); and changing definitions and agency program policies, both serious barriers to trend analysis.

Lash, Trude; Sigal, Heidi; and Dudzinski, Deanna. State of the Child: New York City II. New York: Foundation for Child Development, 1980.

This is the Foundation's second book about the overall status of New York City's Children. Like the first book (published in 1976), this book is a compendium of data encompassing many characteristics concerning children and their environment.

The health chapter is comprehensive. Data sources include vital statistics, program data, and the National Center for Health Statistics, Health Interview Survey. Data included in this chapter are organized as follows:

- Life Chances the First Year - infant mortality, low birth weight, and factors associated with low birth weight
- Childhood Mortality, Illness, and Injury - causes of mortality, poisoning, childhood diseases, and immunization
- Impact of Illness and the Use of Health Services - short-term disability, inpatient care, ambulatory care, health insurance and assistance

Lipsitz, Joan. "A Statistical Portrait of American Adolescents." Common Focus 6(1):1-5, 1985.

This article contains statistical data about adolescents presented by the author (the Director of the Center for Early Adolescence) in testimony before the U.S. House of Representatives Select Committee on Children, Youth, and Families. Organized within five major categories the statistics deemed important included the following:

- Schooling
 - percentage of 17 year olds graduating from high school
 - percentage of 12- to 16-year-olds who want to pursue post-high-school education
 - life table statistics regarding high school graduation
 - dropout rates
- Employment
 - percentage of teenagers with jobs
- Sexual Activity
 - sexual activity among unmarried teenagers by age
 - birth rate - overall and out-of-wedlock
 - death rate among mothers from complications during pregnancy and childbirth

- Substance Abuse
 - percentage of seniors having used marijuana in the past month
 - percentage of teenagers having ever used marijuana
 - percentage of adolescents that smoke one or more cigarettes per week
 - percentage of adolescents that smoke daily or once a week
- Mental Health
 - estimate of the percentage of adolescents that need mental health services
 - suicide deaths per million persons 15-19
 - number of runaways
 - number of reported incidents of child abuse

The author concludes that although the statistics show a decrease in antisocial and personally destructive behavior, the aggregate data mask serious problems within subgroups of the population. The author also notes that, regrettably, statistical overviews generally do not incorporate indicators of adolescents' strengths (e.g., number that volunteer in the community) because such statistics are largely unavailable.

New York State Council on Children and Families. "Issues in Children's Health." Trends, 1(2), 1983.

The health of New York State children has improved steadily since the beginning of the century. In this issue of TRENDS, the Council on Children and Families presents some of the available information regarding children's health status. Detailed information focusing on infant and juvenile mortality, low birth weight, disabilities, illness, and nutrition is provided. These data are presented for the state as a whole, for New York City, and for the balance of the state (that is, the state exclusive of New York City). [Author]

Petit, Michael, and Overcash, Donna. American Children: Powerless and in Need of Powerful Friends. A 1983 Status Report to the National Governors' Association. Augusta: Maine Department of Human Services, 1983.

This statistical report about children in the United States contains facts and figures regarding economic status, education, health, employment, housing, and juvenile justice. Population-based and program data are presented. Health-related indicators include mortality, natality, morbidity, access (i.e., immunization, insurance coverage), special care populations, and substance abuse.

Randolph, Linda A., and Rivers, Sylvia. "A Comparison of Selected Health Indicators for Black and White Children in New York State". New York State Journal of Medicine, 85(4):131-134, 1985.

In this article the authors compare health status and services utilization of black and white children in New York. The indicators include measures of maternal mortality, morbidity, and obstetric hospital discharges. Infant mortality statistics and rates of low birth weight, lead poisoning, and dental care are also compared, as are death rates and major causes of teenage death. Statistics on all indicators show disparities between white and black children. The authors review several major New York State Department of Health programs designed to provide services to high-risk children, mothers and pregnant women. The authors recommend more federal and state programs designed to reach high-risk children at strategic contact points including hospitals, preschool and day care centers, and schools.

Select Committee on Children, Youth, and Families, Ninety-Eighth Congress, First Session. U.S. Children and Their Families: Current Conditions and Recent Trends. Printed for the use of the Select Committee on Children, Youth, and Families, May 1983. Reprinted Washington D.C.: Foundation for Child Development, July 1983.

In this report, tables of statistical trend data regarding children and their families are accompanied by brief interpretations of the data. The national data are presented in seven categories: population, family environment, income, education, health and health-related behavior, behavior and attitudes, and selected government programs affecting children. The data come from a variety of sources, such as the census, vital statistics, and surveys.

Indicators of health and health related behavior include the following:

- prenatal care
- prenatal care and maternal characteristics
- low birth weight
- birth weight and prenatal care
- infant mortality
- deaths among children from disease and accidents
- deaths by homicide
- communicable diseases
- immunization among preschool children
- immunization among children entering school
- physician visits
- physician visits by age, education, and race
- dental visits
- cigarette use
- alcohol and drug use
- adolescent suicide

Trevino, F.M. "Health Indicators for Hispanic, Black, and White Americans." Vital and Health Statistics, Series 10, September 1984, 148:1-88.

Statistics on health characteristics for Mexican Americans, mainland Puerto Ricans, Cuban Americans, and "other Hispanic" populations are compared with those for white and black non-Hispanic persons. The topic areas include utilization of health services as measured by physician visits, dental visits, and hospitalizations; and illness and disability measures including incidence of acute conditions by condition group, days of restricted activity, days spent in bed and days missed from work because of illness and injury, and activity limitation associated with chronic conditions. Estimates are based on data collected in health interviews during 1978, 1979, and 1980. [Authors]

U.S. Department of Health and Human Services, Office of Human Development Services, Administration for Children, Youth, and Families. The Status of Children, Youth, and Families, 1979. Washington, D.C.: U.S. Government Printing Office, 1980.

This report provides a comprehensive overview of the status of children, youth, and families in the United States, a discussion of the key factors related to growth and development, and a discussion of the status of research related to each of these groups. Data derive from a variety of agencies, primarily federal, and are presented as aggregate national statistics. Health-related statistics are presented in text and tables in the second chapter, "Life Cycle Development," as well as the chapters on the status of children, youth, and families.

U.S. Department of Health and Human Services, Public Health Service. Health: United States, Washington D.C.: U.S. Government Printing Office, annual.

This annual publication presents statistics concerning recent national trends in health care and discussions of selected health issues. The major topics addressed and associated statistical data included in the report change from year to year. Although some state-specific data are included, most data are for the general population (all ages).

U.S. Department of Health and Human Services, Public Health Service, Office of Disease Prevention and Health Promotion. Prevention '84/'85. Washington DC: U.S. Government Printing Office, 1985.

This book reviews the nature and scope of Federal activities designed to facilitate accomplishment of our national health objectives, initially described in the 1980 document Promoting Health/Preventing Disease: Objectives for the Nation.

Chapter 1 of Prevention '84/'85 provides a special focus on the health protection activities of the Public Health Service. Chapter 2 reviews progress related to the health of people at each of five major stages of life. Chapter 3 offers an agency-by-agency summary of recent developments in prevention. And Chapter 4 contains the inventories of activities according to each of the 15 priority areas of the 1990 Objectives. The scope of the activities discussed make this volume a unique and valuable resource. [DHHS Transmittal Letter]

U.S. Select Panel. Better Health for Our Children: An National Strategy, Vol. III, Statistical Profile. The report of the Select Panel for Promotion of Child Health to the U.S. Congress and Secretary of Health and Human Services. Washington, D.C.: U.S. Department of Health and Human Services, Public Health Service, Office of the Assistant Secretary for Health and the Surgeon General, DHHS (PHS) Publication Number 79-55071, 1981.

The mandate of the Select Panel for the Promotion of Child Health to develop "a comprehensive plan to promote the health of children and pregnant women" has necessitated an evaluation of the health-related data for women of childbearing age and for children....

The volume is divided into two sections. Section I consists of text and section II of 120 tables.

The text is designed to facilitate interpretation of the tables, to highlight the data, and to provide references to important or recent analytic studies and to major sources of data. It is not designed to analyze all of the data in this volume or in all epidemiological studies. The hope is that it will serve as an introduction to readers who will browse through the tables and find the information they need to make their own interpretations. An index of tables relevant to each chapter is provided at the end of the text and a subject index at the end of the tables to facilitate such use. [Authors]

Washington State Office of Comprehensive Health Planning. Health Indicators Report, 1968-1973. Olympia: Comprehensive Planning Council of Whatcom, Skagit Island, and San Juan Counties, Mount Vernon, Washington, 1975.

Data for 45 health indicators for four counties in Washington between 1968 and 1973 are presented to aid professional and non-professional decision-makers and interested citizens in determining the relative health of this region in comparison with other areas. The indicators were reviewed against several criteria: the existence of a meaningful relationship between the indicators and health status or health risk, availability of data for the indicator, and relative accuracy and completeness of available data. Data were provided by federal, state, and local agencies, and obtained from a number of source documents, which are listed. The tabular format presents the data according to six categories: the first year of life; health of children and youth; enrollment in special programs; injuries, illnesses, and use of health services; societal health

indicators; and mortality. At the bottom of each table is a listing of areas by rank from "best" to "worst," permitting easy comparisons. Each table also contains remarks about significant interregional trends and/or regional standing and remarks about short-term trends. Graphs plot rates over time for the region, state, and nation, and provide a description of data sources and data limitations. [Health Planning and Administration Database]

White House Conference on Children, 1970. Profiles of Children. Washington, D.C.: U.S. Government Printing Office, 1970.

This is a reference book compiled for the 1970 White House Conference on Children. It contains charts and figures covering a broad range of demographic, social, economic, health and educational concerns. More detailed data backing the figures and text are cross-referenced and appended in tables. Health-related indicators cover the following areas:

- infant mortality
- birth rates
- fertility rates
- access to prenatal care and hospital births
- estimated average length of life
- mental retardation
- deaths from accidents by leading causes
- nutrition
- child abuse
- participation in school lunch and nutrition programs
- drug, alcohol, and cigarette use

HEALTH INDEXES

Erickson, Pennifer. Health Effectiveness Measures. In 1984 Proceedings of the Business and Economic Statistics Section. Washington, D.C.: American Statistical Association, 1985.

In the health care sector, assessment of program effectiveness has been complicated by the lack of suitable measures. While morbidity and mortality data are commonly used for health policy decisions, they provide less appropriate answers to the more complex questions now being asked. For instance, is the quality as well as the quantity of life improving? Recent research has focused on developing output measures which combine health information as well as disease-oriented morbidity and mortality data into a continuum ranging from perfect health to death. Development of these measures has proceeded in three stages. The first stage consisted of dividing the continuum into discrete health states. In the second stage, measures of individual preferences for being in each of the states were obtained using such methods as the time tradeoff. The third stage involves the use of simultaneous equation models to estimate transition probabilities between states. This paper analyzes the methods used in the development of these health effectiveness measures and comments on the relevance of the resultant measures for decision making. [Author]

Kirshner, Bram, and Guyatt, Gordon. "A Methodological Framework for Assessing Health Indices." Journal of Chronic Diseases, 38(1):27-36, 1985.

Tests or measures in clinical medicine or the social sciences can be used for three purposes: discriminating between subjects, predicting either prognosis or the results of some other tests, and evaluating change over time. The choices made at each stage of constructing a quality of life index will differ depending on the purpose of the instrument. We explore the implications of index purpose for each stage of instrument development: selection of the item pool, item scaling, item reduction, determination of reliability, of validity, and of responsiveness. At many of these stages, not only are the requirements for discriminative, predictive, and evaluative instruments not complementary, they are actually competing. Attention to instrument purpose will clarify the choices both for those developing quality of life measures and for those selecting an appropriate instrument for clinical studies. [Authors]

Kogan, Leonard, and Jenkins, Shirley. Indicators of Child Health and Welfare: Development of the DIPOV Index. Center for Social Research, Graduate Center, City University of New York. New York: Columbia University Press, 1974.

The purpose of the study was to develop a small set of statistical indicators which could be used to depict the general quality of child health and welfare for different geographic units over time. The units were 62 community districts in New York City, 62 counties in New York State, and 50 states plus the

District of Columbia. Twenty-five indicators were selected, of which approximately half pertained to children and half were regarded as contextual (e.g., tuberculosis, overcrowded housing, family income, crime index). The following health indicators were selected:

- Child attributes and characteristics

- infant mortality - resident deaths under one year
- premature births - resident live births under 2501 grams
- juvenile venereal disease - reported cases of venereal disease (syphilis and gonorrhea) under 20 or 21

- Context attributes and characteristics

- measles, all ages
- TB, new cases
- home accident deaths

- Child resource and service statistics

- pediatricians
- children in mental hospitals (first admissions)
- prenatal neglect - number of women with no care and care in last trimester of pregnancy

- Context resource and service statistics

- mental hospital admissions
- physicians
- psychiatric clinic terminations

A factor analysis was conducted to determine if a small number of independent dimensions could account for the variance. Using the strongest factor, DIPOV (disorganized poverty), the authors developed an index with five indicators: dependency (AFDC), incomplete families (not living with both parents), premature births, out-of-wedlock births, and juvenile venereal disease. The index is interpreted as representing an underlying dimension which is a function of poverty and discrimination. The index was used to measure changes in the quality of child health and welfare in different geographic areas over time, 1960-1970.

National Center for Health Statistics. Bibliography on Health Indexes. Washington D.C.,: Clearinghouse on Health Indexes, Public Health Service, U.S. Department of Health and Human Services, quarterly.

The Clearinghouse publishes the Bibliography on Health Indexes four times each year. This compilation consists of citations of recent reprints or photocopies included in the Clearinghouse file of documents. Each citation in the ANNOTATIONS Section will be followed by a brief summary of the article. The

period covered and the sources used in the compilation will be clearly stated in each issue. At present, the Bibliography, its abstracts and other notes are all printed in English. Also presented in the Bibliography is information about forthcoming conferences, publication of previously cited, forthcoming materials, and new information sources, etc. Addresses of contributors and sponsoring organizations for conferences are given in each Bibliography. [Authors]

National Center for Health Services Research. "NCHSR Research on Health Status Measures." NCHSR Program Notes. Rockville, MD: National Center for Health Services Research, November 1983.

"Interest in health status index development grew out of the need of health services researchers and evaluators for measures that were more comprehensive and sensitive than simple mortality and morbidity measures. The principal needs were to have a more precise way to measure the effectiveness of health services delivery programs and health interventions to determine differential needs for services; to aid in the determination of appropriate levels of care; or to characterize case-mix in institutional populations." (p.1)

This program note describes five different types of extramural health status indicator research and lists indexes and their principal purposes. The categories include general health status indexes, measures of chronic health status and indexes for specific populations, measures of severity and intensive care, risk and lifestyle measures, and case-mix measures.

Several intramural health status index studies for measuring the quality or equity of care are also referenced in this publication.

Sullivan, Daniel F. "Conceptual Problems in Developing an Index of Health." Vital and Health Statistics, Series 2, No. 17. National Center for Health Statistics, Department of Health, Education, and Welfare, 1968.

In this report, the problem of measuring levels of health is discussed with a view to identifying measures indicative of changing health status in the United States population. Traditionally, mortality rates have been used for this purpose, but changing health problems and programs have impaired their utility as a measure of the need for and adequacy of health programs. If new indexes are to be devised, the question of what to measure must be resolved.

Two essential characteristics of an index of health status are identified. It must (1) be sensitive to the need for and adequacy of health activities, and (2) be composed of measurable components. Several concepts of a population's level of health are examined in view of these requirements. A measure of health in terms of mortality and morbidity seems appropriate. This requires an operational definition of morbidity. Examination of various methods of defining and measuring morbidity suggests that formulation of a concept of the total impact of illness might serve this purpose. The impact of illness is

defined in terms of forms of disability which might be measured by crosssectional surveys. Sources of data, problems of reliability and validity, and the use of such a measure in construction of an index are discussed.

This report is presented in the hope that discussion will delineate the problems involved and assist in their solution. [Author]

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